MODEL MIS GUIDELINES

The Contractor's MIS must provide support for all functions of the Plan's processes and procedures related to the flow and use of data within the Plan and have the capability to capture and utilize various data elements for Plan administration and management purposes.

Seven conceptual subsystems are used in the Model MIS Requirements to identify specific functions and capabilities of a Plan's MIS. These subsystems focus on the individual system functions or capabilities which provide support for the following areas:

>   Administration/Planning
>   Financial
>   Enrollee/Eligibility
>   Provider
>   Encounter/Claims Processing
>   Utilization/Quality Improvement/Assurance
>   Reporting

The following is a list of those functions which have not been identified in one of the seven subsystems:

SYSTEM WIDE FUNCTIONS

A.   Functions and Capabilities

>   Systemwide conditions will include:

>   1.   Online inquiry access by the contractor for enrollee and provider eligibility information/verification.

>   2.   Online read-only access by the Department to the contractor's MIS.

>   3.   Provisions for updating and edit processes for all information entered with history of adjustments and audit trail(s) for both current and retroactive data. Monitor errors incurred during update/edit by type of error, frequency and documentation of correction.

>   4.   Supports use of a variety of inputs, including manual, electronic transmission, or other means.

>   5.   Archiving data and backup/restore procedures in the event of system failure.

>   6.   Linkages among all MIS subsystems either automated or manual. (See Administration Subsystem, Financial Subsystem, Enrollee /Eligibility Subsystem, Provider Subsystem, Encounter/Claims Processing Subsystem,Quality Management/Quality Assurance/Utilization Review Subsystem).

>   7.   Interrelate enrollee/provider data with utilization and accounting data.

The seven subsystems consist of the following:

ADMINISTRATION SUBSYSTEM

The administration subsystem supports the day-to-day management of the major plan functions -- financial, enrollment, disenrollment, encounter data recording, claims payment/processing, service utilization, quality assurance, provider contracts, and other administrative and managerial functions. This subsystem also supports long term strategic planning.

The Administration subsystem will have the capability to:

Integrate data from all subsystems/modules that constitute the Contractor's MIS.

FINANCIAL SUBSYSTEM

The financial subsystem should provide the necessary data for all accounting functions including cost accounting, inventory, fixed assets, payroll, general ledger, and financial statement presentation. The financial subsystem should provide management with information that can demonstrate that the proposed or existing health plan is meeting, exceeding, or falling short of fiscal goals. The information should provide management with the necessary tools to spot the early signs of fiscal distress, allowing management to take corrective action where appropriate.

A.   Functions and Capabilities

     The Financial subsystem will have the capability to:

     1.   Provide information relative to a Health Plan's economic resources, the claims to those resources (obligations), and the effects of transactions, events, and circumstances that change resources and claims to resources.

     2.   Provide relevant information. Information is relevant if it provides knowledge concerning past events (feedback value) or future events (predictive value).

     3.   Produce financial statements in conformity with Generally Accepted Accounting Principles.

ENROLLEE/ELIGIBILITY SUBSYSTEM

The enrollee/eligibility subsystem collects, processes, and maintains current and historical information on enrollee(s), enrollee groups, or other plan entities.

A.   Functions and Capabilities

     The Enrollee/Eligibility subsystem will have the capability to:

     1.   Identify other health coverage available or third party liability (TPL).

2. Identify and monitors enrollee needs (i.e. language preference or lack of transportation, etc).

3. Maintain history files.

4. Maintain information on enrollee disenrollments, complaint/grievance activities, including reason or type of disenrollment, complaint or grievance, and resolution by incidence.

5. Translate or edit data received prior to inclusion into Plan's MIS.

6. Provide error reports and a reconciliation process between new data and data existing in MIS.

7. Identify disenrollments by provider.

8. Provide enrollees timely information regarding plan benefits, sites, and any other required information.

9. Monitor PCP capacity and limitations prior to linkage of enrollee to PCP.

10. Assign enrollee to PCP if no choice is made by enrollee.

11. Verify enrollee eligibility for medical services rendered or for other enrollee inquires.

12. Assign each enrollee a unique identification number.

13. Access/search records by a variety of fields (e.g. name, unique identification numbers, date of birth, zip, SSN etc.) for eligibility verification.

PROVIDER SUBSYSTEM

The provider subsystem collects, processes, and maintains current and historical data on program providers, including services, payment methodology, license information, service capacity, and facility linkages.

A. Functions and Capabilities

The Provider subsystem will have the capability to:

1. Identify specialty(s), admission privileges, enrollee linkage, capacity, emergency arrangements or contact, and other limitations or restrictions.

2. Maintain provider history files

3. Maintain provider fee schedules/remuneration agreements.

4. Support Plan credentialing, re-credentialing, and credential tracking processes; incorporates or links information to provider record.

5.   Support monitoring activity for physician to enrollee ratios (actual to maximum) and total provider enrollment to physician and plan capacity.

6.   Edit for duplicate assignment of enrollee to provider.

7.   Monitor and track provider/enrollee complaints grievances/appeals from receipt to disposition or resolution by provider.

8.   Flag and identify provider with restrictive conditions.

ENCOUNTER/CLAIMS PROCESSING SUBSYSTEM

The encounter/claims processing subsystem collects, processes, and stores data on all health services delivered for which the plan is responsible. The functions of this subsystem are claims payment processing and capturing medical service utilization data. The subsystem captures all medically related service, including drug or medical supplies, using standard codes (e.g. CPT-4, HCPCS, ICD9-CM, UB92 Revenue Codes) rendered by medical providers to an eligible plan enrollee regardless of renumeration arrangement (e.g. capitation/fee-for-service). It approves, prepares for payment, or may return or deny claims submitted. This subsystem may integrate manual and automated systems to validate and adjudicate claims and encounters.

A.   Functions and Capabilities

The Encounter/Claims Processing subsystem will have the capability to:

1.   Accommodate various input methods - electronic submission, tape, claim document, magnetic media.

2.   Support entry of a <u>minimum</u> of two diagnosis codes for each service line entry as required by the service rendered.

3.   Edit and audit to ensure allowed services are provided by eligible providers for eligible recipients.

4.   Interface with enrollee and provider files.

5.   Identify and report TPL potential.

6.   Edit for utilization and service criteria, medical policy, fee schedules.

7.   Submit data to the State through electronic transmission.

8.   Support multiple fee schedules for individual providers, groups etc.

9.   Provide timely, accurate, and complete data for monitoring claims processing performance, utilization.

10.   Maintain and apply prepayment edits to verify accuracy and validity of claims data for proper adjudication.

11. Maintain and apply edits and audits to verify timely, accurate, and complete encounter data reporting.

12. Submit encounter data to the Department of Health Services on a monthly basis.

13. Submit all encounter data within 90 days following the end of the reporting month in which the encounter occurred to the Department of Health Services.

14. To provide reimbursement to non-contracted providers for emergency services rendered to enrollees in a timely fashion.

QUALITY MANAGEMENT/QUALITY ASSURANCE/UTILIZATION SUBSYSTEM

The quality management/quality assurance/utilization review subsystem combines data from other subsystems, and/or external systems, to produce reports for analysis which focus on the review and assessment of quality of care given, detection of over and under utilization, and the development of user defined criteria and standards. These reports profile utilization of providers and enrollees and compare them against experience and norms for comparable individuals.

The subsystem supports tracking utilization control function(s) and monitoring activities for inpatient admissions, emergency room use, ancillary, and out-of-area services. It provides profiles, occurrence reporting, monitoring and evaluation studies, and enrollee satisfaction survey compilations. The subsystem may integrate plan's manual and automated processes or incorporate other software reporting and/or analysis programs.

The subsystem incorporates and summarizes information from enrollee surveys, provider and enrollee complaints, and grievance/ appeal processes.

A. Functions and Capabilities

The Quality Management/Quality Assurance/Utilization Review subsystem will have the capability to:

1. Develop and establishment Plan performance measurement standards.

2. Support Plan processes to monitor and identify deviations in patterns of treatment from established standards or norms. Provides feedback information for monitoring progress toward goals, identifying optimal practices, and promoting continuous improvement).

3. Support development of cost and utilization reports by provider and service.

4. Provide aggregate performance measures using standardized quality indicators similar to HEDIS.

5. Support the management of referral/utilization control processes and procedures.

6.   Edit referral-utilization control data for completeness and accuracy.

7.   Support functions of reviewing access, use and coordination of services (i.e. track prescription drug utilization; actions of Peer Review and alert/flag for review and/or follow-up; laboratory, x-ray and other ancillary service utilization per visit.)

8.   Store patient satisfaction data through use of enrollee surveys, grievance, complaint/appeals processes etc.

REPORTING SUBSYSTEM

The reporting subsystem supports reporting requirements for the health plan management and Department of Health Services (DHS) of all plan operations. It allows the health plan to develop various reports to enable plan management and DHS to make intelligent decisions regarding health plan activity.

A.   Functions and Capabilities

The Reporting subsystem will have the capability to:

1.   Produce all standard, Department-defined and ad hoc reports from the data available in all MIS subsystems. Reporting media for encounter data will consist of telecommunication, diskette or tape. All other reports will be submitted both on hard copy and diskette in ASCII format unless otherwise agreed between the Contractor and the Department (see Section 9.4 Management Information Systems and Section 16, Attachment 9.4.-B for a complete description of Department data and reporting requirements).

2.   Adjust to flexible reporting periods to permit the development of reports at irregular periods as needed.

3.   Generate reports which provide unduplicated counts of enrollees, providers, payments and units of service unless otherwise specified.

B.   Health Services Delivery Measures

Health delivery measures must not only identify that an event has occurred, but also identify why a particular event or trend is occurring. There are certain measures that allow a health plan to identify and assess deviations (positive or negative) in the delivery of health care. The following list is not meant to encompass all the performance measures that should be routinely available to HMO managers, but is designed to provide many of the common and most critical measurement tools. The following list identifies commonly used indicators:

1.   Inpatient bed days: all actual utilization should be reported for actual, expected (i.e. anticipated or budgeted) and the variance for the current period and year-to-date. It should be reported in days, days per 1,000 members, and as a percentage for the following categories:

    a.   Total inpatient days:

          *   Inpatient days by hospital and by service (e.g. orthopaedics)
          *   Inpatient days by admitting physician and by pcp.
          *   Inpatient days by age and sex and by group

2.   <u>Hospital discharges:</u> all discharges (or admissions) should be reported for actual, expected (i.e., anticipated of budget) and the variance for the current period and year-to-data. They should be reported in discharges, discharges per 1,000 members, and by average length of stay for the following:

    a.   Total discharges:

          *   Discharges by hospital and by service
          *   Discharges by admitting physician and by PCP
          *   Discharges by age and sex and group

3.   <u>Primary Care Physician Visits:</u> all visits should be reported for actual, expected (i.e., anticipated or budget) and the variance for the current period and year-to-date. They should be reported in the number of visits per member per year for the following:

    a.   Total PCP visits:

          *   PCP visits by PCP
          *   PCP visits by type (e.g., initial, return)
          *   PCP visits by age and sex and group

4.   <u>Specialist/referrals Visits:</u> All visits should be reported for actual, expected (i.e. anticipated or budget) and the variance for the current period and year-to-date. They should be reported in number of visits and number of visits per member per year for the following:

    a.   Total Specialist visits:

          *   Specialist visits by PCP
          *   Specialist visits by type (e.g., initial, return) and by service (e.g. neurology)
          *   Specialist visits by age and sex and group

5.   <u>Other Medical Services:</u> All visits should be reported for actual, expected (i.e., anticipated or budget) and the variance for the current period and year-to-date. They should be reported in number of visits and number of visits per member per year for the following:

    a.   Other Medical Service Visits:

          *   Visits by PCP
          *   Visits by service (e.g., X-ray)
          *   Visits by age and sex and group

6. Member Clinical History: ability to report on the performance of individual physicians, especially PCPs, in comparison to their peers (e.g., internists, family practice, etc) and to the expected (i.e., anticipated or budgeted) for a variety of measures:

    a. Financial Measures on a per-member per-month basis:

        *   Payments to physicians for capitated services.
        *   Payments to physicians for non-capitated services.
        *   Amount withheld on capitated payments.
        *   Amount withheld on non-capitated payments.
        *   Claims costs for referral services by PCP and by service.
        *   Claims costs for hospital services by PCP and by service.
        *   Claims costs for other medical services by PCP and by service.

    b. Utilization measures:

        Inpatient days per 1,000 enrollees by PCP and by service.
        Specialist visits per member per year by PCP and by service.
        Other medical services per member per year by PCP and by service.

    c. Enrollment measures:

        Number of enrollees by PCP and by age, sex, and group.

    d. Enrollment measures: the number of members and contracts should be reported to management on a regular basis for the following categories:

        Total members:

        By age and sex and contract type (family, individual, etc.)